SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: CS/SB 2192

SPONSOR: Banking and Insurance Committee and Senator Sanderson

SUBJECT: Solvency of Insurers and Health Maintenance Organizations

DATE: March 4, 2002 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Emrich	Deffenbaugh	BI	Favorable/CS
2.			HC	
3.			GO	
4.				
5.				
6.				

I. Summary:

Committee Substitute for Senate Bill 2192 revises various provisions relating to the authority of the Department of Insurance in regulating the solvency of insurers and HMOs and other managed care entities, as well as providing for the transfer of HMO payment obligations to other entities, and the payment of dividends or distributions by HMOs.

Under current law, the Department of Insurance (Department) has specified procedures when it determines through financial reports, examinations, or other sources that an insurance company or health maintenance organization (HMO) has failed certain solvency tests or is otherwise in unsound financial condition. The department may place such entities of "unsound condition" under administrative supervision. Administrative supervision allows the department, with the consent of a financially troubled company, to supervise the management of the company in an attempt to cure the company's troubles rather than close it down.

The grounds for placing an insurer or HMO under administrative supervision are expanded under this bill to include the grounds for rehabilitating a company through a delinquency proceeding, and the Department is authorized to adopt rules defining standards of hazardous financial condition and corrective action similar to the model adopted by the National Association of Insurance Commissioners. The bill provides that an order placing a company under administrative supervision could not be stayed during review by the Department.

Health Maintenance Organizations would be required to include in the actuarial certification of their annual report an assurance that they have adequately reserved for liabilities associated with transfers of payment obligations. Such organizations would not be permitted to exclude liabilities associated with these transfers if the provider has not received payment, unless the payment

obligations are secured by a financial instrument. Health maintenance organizations would also no longer be required to file a quarterly report for the 4th quarter.

Health maintenance organizations could invest a portion (5% of admitted assets or 25% of excess surplus, whichever is less) of their excess surplus in investments not specifically authorized under current law as long as the investment is not already expressly prohibited by Chapter 641, F.S. This would allow HMOs to invest in similar types of investments as insurers are allowed to do currently.

Unless prior written approval is obtained from the Department of Insurance, HMOs would be prohibited from paying dividends to stockholders if payment would create negative retained earnings. Dividends equal to or less than the greater of 10 percent of retained earnings or prior year net income would be permitted if surplus is 115 percent of the minimum requirement, and the Department is notified 30 days prior to payment. Criteria also would be established for the Department to consider before approving certain dividend or distribution payments.

The bill further clarifies current law provisions relating to charitable gift annuities by remedying the method for calculating reserves and by clarifying the types of assets in which reserves and surplus may be invested. Finally, workers' compensation insurers would be allowed to calculate liabilities under permitted practice provisions currently allowed in some instances by the Department of Insurance.

This bill substantially amends the following sections of the Florida Statutes: 624.404, 624.80, 624.81, 624.84, 625.041, 627.481, 641.26, 641.35, 641.365, and 641.19.

II. Present Situation:

Insurers and Health Maintenance Organizations

The Florida Insurance Code[1] regulates the business of insurance in the state. Under the Code, the Department of Insurance (Department) has a wide range of options when it determines through financial reports, examinations, or other sources that an insurer has failed, or is at risk of failing, any of the solvency tests or is otherwise in unsound financial condition. General powers of the Department include the authority to suspend or revoke an insurer's certificate of authority; impose administrative fines; issue cease-and-desist orders; and remove, suspend, or restrict the activities of those individuals operating or directing the affairs of the insurer.

In addition to these general powers, the Department may place insurers of "unsound condition"[2] under administrative supervision[3] or attempt to place the insolvent insurer in receivership, with

[1] Chapters 624-632, 634, 635, 641, 642, 648, and 651 constitute the "Florida Insurance Code." S. 624.01, F.S.

[2] "Unsound condition" means any of the following conditions: (a) The insurer's required surplus, capital, or capital stock is impaired to an extent prohibited by law; (b) The insurer continues to write new business when it has not maintained the required surplus or capital; or (c) The insurer attempts to dissolve or liquidate without first having made provisions, satisfactory to the Department, for liabilities arising from insurance policies issued by the insurer. (s. 624.80(2), F.S.)

[3] "Administrative supervision" is an administrative proceeding initiated by the Department directing an insurer that is exceeding its powers or is of unsound condition to take certain corrective actions. (s. 624.81(2), F.S.) This is in contrast to a "receivership," a judicial proceeding in which a court places an insolvent insurer under the control of the Department to preserve its assets for the benefit of affected parties. (ch. 631, F.S.)

or without the consent of the insurer.[4] Administrative supervision is an administrative proceeding in which the Department, with the consent of a financially troubled insurance company, supervises the management of the insurance company in an attempt to cure the company's troubles rather than close it down. Receivership is a judicial proceeding in which the Department is placed in control of the insurer for the purpose of rehabilitating or liquidating the insurer. The Department may seek to be appointed Receiver[5] through a delinquency proceeding in court for the purpose of rehabilitating an impaired insurer or, if rehabilitation is unsuccessful or otherwise inappropriate, liquidating the insolvent company. The primary goal of rehabilitation is to restore the financial solvency of the insurer while the primary goal of liquidation is to secure and maximize the assets of the insolvent company for the benefit of its policyholders.

Under present law, the Department of Insurance regulates health maintenance organization (HMO) finances, contracting, and marketing activities under part I of ch. 641, F.S., while the Agency for Health Care Administration regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a Certificate of Authority from the Department, an HMO must receive a Health Care Provider Certificate from the Agency. Any entity that is issued a certificate under part III of chapter 641, F.S., and that is otherwise in compliance with the licensure provisions under part I, may enter into contracts in Florida to provide an agreed-upon set of comprehensive health care services to subscribers in exchange for a prepaid per capita sum or prepaid aggregate fixed sum. Under s. 641.284, F.S., the administrative supervision and delinquency provisions described in this analysis apply to HMOs and are the "sole" and exclusive means of liquidating, reorganizing, rehabilitating, or conserving an HMO.

Administrative Supervision

The Department may place an insurer and HMO[6] under administrative supervision if, upon examination or at any other time, the Department determines that:

- the insurer is in "unsound condition;"
- the methods or practices of the insurer render the continuance of its business hazardous to the pubic or to its insureds; or
- the insurer has exceeded its powers granted under its certificate of authority or applicable law.[7]

Fifteen days from the date of the notice of the department's determination to place the insurer under administrative supervision, the company must submit a corrective action plan to the Department to remedy the conditions set forth in the notice.[8] If the insurer does not submit such a

[4] Part VI of Ch. 624, F.S.
[5] A receiver is "a person appointed by a court for the purpose of preserving property of a debtor pending an action against him, or applying the property in satisfaction of a creditor's claim, whenever there is danger that, in the absence of such an appointment, the property will be lost, removed or injured." Black's Law Dictionary, 7th Ed. 1990. In this case, the debtor is the insolvent insurer and the creditor is the claimant policyholder (and/or others such as lenders, lienholders, and contractors). Since the Receiver in a delinquency proceeding under Ch. 631, F.S., may exercise powers and duties beyond the scope of a traditional receiver, s. 631.011(15), F.S., defines "Receiver" to mean receiver, liquidator, rehabilitator, or conservator.
[6] For purposes of this section of the analysis, the term "insurer" applies to HMOs.
[7] S. 624.81(2), F.S.
[8] S. 624.81(3), F.S.

plan, then the Department can impose a corrective plan. The Department may require insurers to obtain its approval before engaging in certain activities, including disposing of any assets; investing funds; lending, transferring, or withdrawing funds; incurring debts; entering into reinsurance contracts; terminating policies; releasing premium deposits; or merging with another company.[9]

An insurer may contest an action or proposed action while under supervision on the ground that it would not result in improving its condition.[10] The request will stay the action pending reconsideration by the Department. If the Department upon reconsideration upholds the action, then the stay will be lifted. The insurer would then be entitled to challenge the action of the Department in an administrative hearing under the Administrative Procedure Act (ch. 120, F.S.).

Credit for Reinsurance

Insurance companies authorized in Florida that buy reinsurance are allowed to receive credit on their financial statements if the reinsurance is a type that is authorized, accredited or trusteed.[11] For example, an insurer is limited by state law as to the amount of premiums it may write as a percentage of its surplus ("premium to surplus ratio"). By buying reinsurance and ceding premiums to a reinsurer, the insurance company may obtain credit on its financial statements and deduct the ceded premiums from its net premium to surplus limitations. The insurer buying the reinsurance is referred to as the ceding insurer and the reinsurer is referred to as the assuming insurer. The term “approved reinsurer” is no longer used in the context of reinsurance.

Charitable Gift Annuities

Charitable entities in Florida are permitted under current law to issue charitable gift annuities as a means of supporting their organizations and providing income to their donors.[12] Florida law requires charities that issue such annuities to comply with certain requirements, including the maintenance of minimum reserves and surplus. The statute also sets forth the types and the diversification of the assets that support such reserves and surplus, which are the same as the requirements relating to insurance companies. Companies that issue charitable gift annuity agreements must notify the Department and certify that they are in compliance with the provisions of law on an annual basis. According to representatives with the Department, the current law does not provide a clear and understandable method for calculating reserves and the law is unclear as to the types of assets in which the reserves and surplus may be invested.

Special Disability Trust Fund

The Special Disability Trust Fund, or "second-injury fund," is established in chapter 440, F.S., the workers' compensation law.[13] The SDTF was created to facilitate the reemployment of a worker with a disability or reemployment of a worker following an injury by reducing an employer's insurance premium for reemploying an injured worker and decreasing litigation

[9] S. 624.83, F.S.
[10] S. 624.84, F.S.
[11] S. 624.610, F.S.
[12] S. 627.481, F.S.
[13] S. 440.49, F.S.

between carriers concerning apportionment issues. In addition, the SDTF was created to protect employers from excess liability for compensation and medical expenses when an injury to a physically disabled worker mergers with, aggravates, or accelerates a preexisting permanent physical impairment.

The Division of Workers' Compensation, within the Department of Labor and Employment Security is responsible for the administration of the SDTF. In 1997, the SDTF was terminated prospectively, for accidents occurring on or after January 1, 1998, and its assessment rate for insurers and self-insurers was capped at a 4.52 percent cap.[14] The SDTF is maintained by an annual assessment on net premiums upon insurance companies writing workers' compensation in Florida, commercial self-insurers, the assessable mutuals, and the self-insurers. The assessments are payable on a quarterly basis. The Division of Workers' Compensation is required to estimate annually *in advance* the amount necessary to maintain the SDTF. Pursuant to s. 440.49(9), F.S., the assessment is calculated to produce during the following calendar year an amount which, when combined with that part of the balance in the SDTF, on June 30 of the current fiscal year which is in excess of $100,000, is equal to the average of:

1. The sum of disbursements from the SDTF during the immediate past 3 years, and
2. Two times the disbursement of the most recent calendar year.

The SDTF discounted liability, as of September 30, 2001, is estimated to be $1.42 billion. The specified insurance companies noted above must pay off this deficit by paying SDTF assessments at the maximum rate of 4.52 percent of premium until the deficit is extinguished which is projected to be necessary for many years. Current law specifies uniform accounting procedures,[15] which require such insurance companies to book their share of future SDTF assessments as a liability if it is likely to be incurred and the amount can be reasonably estimated. Since statutory accounting is a very conservative method of accounting, these uniform accounting principles require insurers to book a liability for the *entire amount* of all future assessments.

The amount of all future SDTF assessments for any one carrier can become quite large if the carrier writes a large volume of workers compensation premium in this state. Because of these uniform accounting procedures, some workers compensation carriers in this state have asked the Department of Insurance to grant them a special "permitted practice" so that they can account for the SDTF assessments in a manner *different from* that prescribed by the uniform procedures. The Department has allowed those carriers to book only the *current year* SDTF assessments as a liability under the permitted practice.

HMO Reporting and Transfer of Payment Obligations ("Downstreaming")

Every HMO must file with the Department an annual report including various financial statements as well as contract and claims information, along with an actuarial certification that:

[14] Ch. 97-262, L.O.F.

[15] As defined in the National Association of Insurance Commissioners Accounting Practices and Procedures Manual (usually referred to as codification, specifically as the Statement of Statutory Accounting Principles (SSAP) No. 35,) adopted effective January 1, 2001, by Ch. 2001-213, L.O.F.; s. 625.01115, F.S. This law conforms all accounting provisions of the Florida Insurance Code for insurance companies and health maintenance organizations.

- the HMO is actuarially sound (which certification considers the rates, benefits, and expenses of, and any other funds available for payment of obligation of the organization);
- the rates charged are actuarially adequate to the end of the period for which rates have been guaranteed; and
- adequate provision is made for incurred but not reported claims, and claims reported but not fully paid.[16]

The annual report must be filed by the HMO within 3 months after the end of its fiscal year. In addition, every HMO must file quarterly an unaudited financial statement within 45 days after each of its quarterly reporting periods. However, Florida is the only state requiring HMOs to file such statements for the 4th quarter.

At times, an HMO may contract with and compensate unregulated entities to provide healthcare services to the HMO's subscribers such as paying claims. This is done frequently through a capitation or other financial arrangement and is referred to as "downstreaming."[17] The HMO may then reduce its recorded liability for these obligations on the basis that the payment responsibility has been transferred. If the unregulated entity becomes unwilling or unable to satisfy these obligations, then the HMO is responsible for the liability.[18]

HMO Dividends and Distributions

Under present law, dividends paid by an HMO to stockholders cannot exceed 10 percent of its retained earnings (surplus) *plus* 100 percent of its prior year net income.[19] As a result, HMOs may pay dividends in the amount of their prior year net income even though their accumulated retained earnings account is negative. Some HMOs elect to be taxed in a manner similar to partners of a general partnership. Therefore, shareholders of these S-corporations have a tax incentive to annually distribute the HMO's prior year taxable income because the shareholders pay income tax on the HMO's taxable income whether or not distributed. Under the example offered below, the HMO may distribute $2,360,484, even though it had no accumulated retained earnings in the current year. In this case, the HMO distributed an even greater amount than it had earned in the current year.

EXAMPLE:[20]

Net income – 1998	2,360,484
Retained earnings (deficit), 1/1/99	(4,622,019)
Net income - 1999	630,853
Dividends paid - 1999	(2,976,627)
Retained earnings (deficit), 12/31/99	(6,967,793)

[16] S. 641.26, F.S.
[17] S. 641.35, F.S.
[18] S. 641.3154(3), F.S.
[19] S. 641.365(1), F.S.
[20] From the Department of Insurance

III. Effect of Proposed Changes:

Section 1. Amends s. 624.404, F.S., to clarify the definition of a "fronting company," by deleting the term "approved reinsurer" and replacing it with the reference "to the existing standards for acceptable reinsurers as defined in the reinsurance law under s. 624.610(3)(a), (b) and (c)." The term "fronting company" is currently defined as an authorized insurer which by reinsurance or otherwise generally transfers more than 50 percent to one unauthorized insurer which is not an approved reinsurer, or more than 75 percent to two or more unauthorized insurers which are not approved reinsurers, of the entire risk of loss on all insurance written by it in the state, or on one or more lines of insurance, without obtaining prior approval from the state. The term "approved reinsurer" is no longer relevant in the context of reinsurance.

Section 2. Amends s. 624.80, F.S., relating to the definition of "unsound condition," to add another condition to the criteria the Department of Insurance uses to determine whether an insurer is in "unsound condition." It adds the condition that an "insurer meets one or more of the grounds in s. 631.051 for the appointment of the department as receiver." Section 631.051, F.S., establishes the various criteria for which the department may petition for an order directing it to rehabilitate an insurer.

Section 3. Amends s. 624.81, F.S., applying to notice provisions relating to administrative supervision, to authorize the Department to issue an order placing an insurer in administrative supervision and to require the insurer to take such corrective action as may be necessary to remove the causes and conditions giving rise to the need for administrative supervision.

It provides authority for the Department to promulgate rules consistent with specified model rules of the National Association of Insurance Commissioners (NAIC). According to representatives with the Department, the NAIC issued a management comment to the Department indicating that its laws were deficient because the agency didn't have authority to order companies to take certain action if they were deemed to be in hazardous financial condition. This section does three things: it gives the Department authority to mandate companies take actions to improve their financial condition; it eliminates the NAIC deficiency comment; and, allows the Department to promulgate rules consistent with NAIC model rules which define standards relative to companies deemed to be in hazardous financial condition.

Section 4. Amends s. 624.84, F.S., relating to review of Department orders, to clarify that an insurer's right for review before the Division of Administrative Hearings (DOAH) under s. 120.57, F.S., of a Department order placing such insurer under administrative supervision does not operate as an automatic stay of the order. Also, the bill clarifies that during the period of supervision, an insurer may contest an action by the Department to DOAH, but such an appeal would not operate as an automatic stay.

Section 5. Amends s. 625.041, F.S., relating to liability provisions, to make this provision retroactive to January 1, 2002, and to require that a workers' compensation insurer include as liabilities on their financial statements only the Special Disability Trust Fund (SDTF) annual assessments that the insurer has actually received and such assessments that the insurer has been notified in writing are or will be due and payable. The effect of this provision would codify the "permitted practice" that the Department has already granted to some workers compensation

carriers by allowing them to book a liability for only the current year SDTF assessments as opposed to recording *all future assessments* capable of being estimated as current liabilities.

Section 6. Amends s. 627.481, F.S., relating to requirements for annuity agreements, to address the financial requirements for charitable organizations that are authorized by the Department of Insurance to issue donor annuity agreements. The current law does not clearly establish the method for calculating reserves, and the types of assets in which the reserves and surplus may be invested in also unclear. The bill clarifies the current law, specifies the method for calculating reserves, and provides more specific investment requirements.

Section 7. Amends s. 641.26, F.S., relating to annual reports, to require HMOs to include in their annual actuarial certifications assurance that they have adequately reserved for liabilities associated with downstream risks that are required by s. 641.35(3)(a), F.S. (Section 8 of the bill). The bill would eliminate the requirement for HMOs to file a 4th quarter report, and specifies the due dates for the filing of their 1st, 2nd, and 3rd quarterly reports. The bill also requires HMOs to file quarterly reports and the annual report with the NAIC, and to pay fees to the NAIC rather that to the Department, which they must do currently.

Section 8. Amends s. 641.35, F.S., relating to assets, liabilities, and investments. This provision provides that if an HMO (through a capitation or other arrangement) transfers to any entity other than this state, the United States, or any agency thereof, or to an authorized insurer or HMO, the obligation to pay any provider for any claim, for purposes of determining the financial condition of the HMO, to include liabilities associated with transfers of payment obligations to third parties for which the provider has not received payment, unless the payment obligations are secured by a financial instrument acceptable to the department which assures full payment of those claims.

The bill allows health maintenance organizations to invest a portion (5% of admitted assets or 25% of excess surplus, whichever is less) of their excess surplus in investments not specifically authorized under current law as long as the investment is not already expressly prohibited by Chapter 641, F.S. This would allow HMOs to invest in similar types of investments as insurers are allowed to do currently.

Section 9. Amends s. 641.365, F.S., applying to dividends, to provide that HMOs may not pay dividends or distributions if their surplus funds would be less than zero, and to place limits on HMO dividends or distributions similar to those applied to domestic stock insurers under s. 628.371, F.S. This provision would prohibit dividend payments by HMOs to the extent that they would create negative retained earnings. It would permit dividends equal to or less than the greater of 10 percent of accumulated surplus funds or prior year net income, if such surplus is 115 percent of the minimum required statutory surplus after the dividend is made, and the Department is notified 30 days prior to the dividend payment. This provision also sets forth criteria for the Department to consider when approving dividends in excess of the maximum amount allowed under the provisions noted above.

Section 10. Amends s. 641.19, F.S., to define a "health care risk contract" under the provisions for health maintenance organizations (HMOs), to state that such a contract is one in which an individual or entity receives consideration or other compensation in an amount greater

than 1 percent of the HMOs annual gross written premium in exchange for providing to the HMO a provider network or other services, which may include administrative services. The 1 percent threshold must be calculated on a contract-by-contract basis for each such individual or entity and not in the aggregate for all health care risk contracts.

Section 11. Provides for an effective date of October 1, 2002.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

This bill would prohibit dividend payments by HMOs to shareholders to the extent that such payments would create negative retained earnings under specified circumstances. Placing these restrictions on the payment of dividends or distributions to shareholders would therefore limit the income of such shareholders.

According to representatives with the Department, this bill will enhance the ability of the department to monitor and direct the actions of companies in hazardous financial condition and allow early intervention with troubled companies which would reduce the number of eventual insolvencies. Prevention of insolvencies not only benefits policyholders of the troubled company, but also reduces or eliminates assessment to other carriers that cover the claims costs of an insolvent insurer or HMO.

There will be a revenue savings for HMOs since they will no longer be required to file a 4th quarter report.

HMOs may incur costs by having to provide a financial instrument, under specified circumstances, assuring their payment when such organizations enter into health care risk contracts to transfer payment obligations.

C. Government Sector Impact:

There would be a revenue savings of an indeterminate amount associated with a workload reduction by eliminating the requirements that HMOs file a report for the 4th quarter.

The Department would be authorized to adopt rules consistent with the NAIC's 1997 "Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition." There would be a minimum (indeterminate) expense to the Department associated with adopting such rules.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.

This Senate staff analysis does not reflect the intent or official position of the bill's sponsor or the Florida Senate.